TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

CORRECTED FISCAL MEMORANDUM

HB 963 – SB 937

February 7, 2016

SUMMARY OF ORIGINAL BILL: Creates the *Healthcare Provider Stability Act* (act). Prohibits a health insurer, third-party administrator (TPA), healthcare provider, or other person from effecting a material change to a previously agreed upon rate of payment for which a healthcare provider is paid for providing items or services more than once during a one year period. Requires a TPA or healthcare provider to send written notice of a material change to the other party sixty days prior to the effective date of such change. A healthcare provider or TPA may maintain an individual or class action as the sole remedy to enforce the provisions of the bill. Defines "material change" as a change in fees or payment methodologies that a reasonable person would attach importance to in determining the action to be taken upon the change. Exempts the state, local government, and local education insurance plans, the TennCare program, or any health plan administered by the Division of Health Care Finance and Administration from the provisions of the bill. Also exempts any entity that is subject to delinquency proceedings and for which the Commissioner of the Department of Commerce and Insurance has been appointed receiver or any entity placed under administrative supervision by order of the Commissioner. Applies to all policies, contracts, and health benefit plans issued, delivered, or renewed on or after October 1, 2015.

FISCAL IMPACT OF ORIGINAL BILL:

Increase State Expenditures – Not Significant

Other Fiscal Impact – Any change to the network rates of the carriers contracted with the state employee, local government, and local education health plans could indirectly affect the rates for these plans; the indirect impact of which cannot be reasonably determined.

IMPACT TO COMMERCE OF ORIGINAL BILL:

Other Impact to Commerce - Due to a number of unknown factors, the impact to commerce cannot reasonably be determined.

SUMMARY OF AMENDMENT (011807): Deletes all language after the enacting clause. Requires health insurance entities to maintain detailed descriptions of coding guidelines, policies, methodologies, and processes that would impact coverage or payment of items and services that are expected to be applied to claims; a description of other applicable policies or

procedures the entity may use that affect the payment of specific claims including policies and procedures affecting recoupment, copayment, coinsurance, and deductibles; clearly identify any source outside the health insurance entity's control and the source's website or citation if a source is used as a basis for determining the amount of payments to healthcare providers; and information related to any methodology using a relative value system; and the publisher and product description of software used to edit claims. Prohibits a health insurance entity from making a change to a provider's fee schedule except for one-time during any 12-month period or if a health insurance entity and a hospital agree in writing to a change in the fee schedule. This prohibition does not apply to changes effected by federal or state government; certain reimbursements for drugs, immunizations, or injectables; any changes or additions to the list of Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System; any changes or additions to revenue codes established by the National Uniform Billing Committee; and specified changes in the provider's fee schedule previously agreed to in the provider's agreement with the health insurance entity. Authorizes a health insurance entity to effect a change to any policies, procedures, or methodologies up to four times during a consecutive twelve-month period except for limited exclusions included within the bill.

Establishes requirements between health insurance entities and healthcare providers and provider network contract amendments, including fee schedule disclosures and possible terminations of other network agreements based on a provider's decision. The provisions of the bill as amended above do not apply to the state employee, local education, and local government insurance plans or the health plans administered by the Division of Health Care Finance and Administration, including TennCare, Cover Kids, and AccessTN.

Requires health insurance entities to provide the payment or fee schedules and all other information sufficient to enable the healthcare provider to determine the manner and amount of payments under the contract prior to the final execution or renewal of the contract. The health insurance entity shall make available to the healthcare provider access, free of charge, to that provider's individual fee schedule in an industry standard spreadsheet format. A health insurance entity has discretion to provide the fee schedule in one of the following formats: delivered via electronic mail; maintain the provider's fee schedule on a secure website; or deliver a paper copy via U.S. mail for a reasonable fee. Requires health insurance entities to provide notice of any change to the provider's fee schedule at least 90 days prior to the effective date of the change.

Authorizes a provider to make a written request for a copy of the policies or fee schedule that were in effect during the audit period within 10 business days of receipt of notification that the health insurance entity's audit is complete. The health insurance entity shall furnish or make available payment policies that were in effect during the audit period within 10 business days after receiving the written request.

The provisions of the bill as amended will take effect July 1, 2017, and apply to all contracts, renewals, and amendments entered into by a healthcare provider and a health insurance entity on or after that date.

FISCAL IMPACT OF BILL WITH PROPOSED AMENDMENT:

On February 2, 2016, a fiscal memorandum was issued with the following impact:

> *Other Fiscal Impact – Any additional claims costs of the state sponsored group health plans are difficult to determine due to all the varying factors that play into claims cost. Any change to the network rates of the carriers contracted with the state employee, local government, and local education health plans could indirectly affect the rates for these plans. Based on an actuarial report, a possible increase in claims expenditures in FY17-18 could be $667,400 in state funds and $36,200 in federal funds.*

After the issuance of the fiscal memorandum, information was received from the Department of Commerce and Insurance and the Department of Finance and Administration which rendered the fiscal impact incorrect. The estimated fiscal estimate is as follows:

> **(CORRECTED)**
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> **Increase State Revenue - $945,000/One-Time**
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> **Other Fiscal Impact – Any additional claims costs of the state sponsored group health plans are difficult to determine due to all the varying factors that play into claims cost. Any change to the network rates of the carriers contracted with the state employee, local government, and local education health plans could indirectly affect the rates for these plans. Based on an actuarial report, a possible increase in claims expenditures in FY17-18 would be $875,700 in state funds and $36,200 in federal funds.**

Assumptions for the bill as amended:

- Effective date is July 1, 2017.

Department of Commerce and Insurance:

- The Department of Commerce and Insurance will be responsible for enforcing the provisions of the bill as amended related to health insurance carriers. This enforcement will be accomplished through the investigation of any complaints against health benefit plans. This requirement will not significantly increase the department's workload.
- Based on information provided by the Department of Commerce and Insurance, any increase in expenditures incurred by health insurance companies in the state will result in revenue generated from a 1.75 percent tax on expenditures.
- One-time administrative costs for health insurance carriers in the state have ranged from $10,000,000 to $16,000,000 per carrier. A report completed by an insurance regulatory consulting firm at the request of the Department of Commerce and Insurance estimates

costs per carrier could easily exceed $8,600,000. For purposes of the fiscal analysis, it is reasonably estimated that any costs will average $9,000,000 per insurance carrier.

- The Department of Commerce and Insurance believes these costs will be incurred by six health insurance carriers in the state resulting in an increase in one-time tax revenue of $945,000 ($9,000,000 x 6 carriers x 0.0175).
- Should health insurance carriers increase health insurance premiums to recover the additional costs, there could be additional revenue realized. Due to the various factors that are incorporated into premium rates, a change in premium tax revenue cannot be quantified.

Division of Health Care Finance and Administration:

- The health care programs administered by the Division of Health Care Finance and Administration are exempted from the provisions in Sections 1, 2, and 3 of the bill as amended.
- The provisions of the bill as amended will require the vendors contracted with the Division of Health Care Finance and Administration (HCFA) to provide benefits through the TennCare program, the CoverKids program, and the AccessTN program to make website modifications including user interface modifications, increase existing functionality, and data management.
- *Section 4*: Current Tenn. Code Ann. § 56-7-1013 (c) is being amended to require health insurance entities to provide a healthcare provider access, free of charge, to the provider's individual fee schedule by maintaining the fee schedule on a secure web site, through email, or in a hard copy so that access to the fee schedule is available at any time throughout the term of the provider's contract with the health insurance entity. Since the method of providing the fee schedule is at the discretion of the health care entity, it is assumed TennCare contract vendors will be able to provide the requested fee schedule without incurring a significant fiscal impact.

Division of Benefits Administration:

- Currently, the state sponsored groups plans contract with two carriers and use their networks to provide benefits to enrollees. The state recently entered into new contracts with these carriers. The contracted payment schedule is based on a tiered per member per month administrative fee. These fees are set for January 1, 2016 – December 31, 2020. In order for administrative costs incurred by the two carriers to be passed on to the state and local employee group plans, the contracts will have to be amended.
- The Division of Benefits Administration reports the following costs will be incurred by their vendors and could be passed on to the state and local employee group plans if the contracts are amended in the future.
- *Sections 2 and 3:* Both of the vendors will incur the following one-time costs related to the building of a provider portal for each provider to utilize to ascertain data by network to meet the requirements of the bill as amended. Due to the fee schedule and terms in the current contracts, in order for these costs to be passed down to the state and local employee group plans, the contracts would have to be amended to include the costs. Due to this uncertainty, these costs have not been included in the overall costs to the state and local group health plans.

- *Section 3:* Due to a number of unknown factors, including but not limited to, the timeframe in which any provider network reimbursement costs will increase, the possible increased volatility that could affect the provider networks, how this volatility will impact provider rates and the provider network itself, and how this will in turn affect the state employee, local government, and local education health plans, any increase in expenditures to the state health plan or the fiscal year in which these expenditures will occur are difficult to quantify.
- If additional costs are incurred within a carrier's commercial networks, there could be an indirect increase in network rates that could subsequently affect the costs associated with the state employee, local government, and local education insurance plans. Any network rate changes will be based on a number of factors that are unknown.
- Based on a memo from the Division of Benefits Administration's contracted actuary dated January 27, 2016, the actuary projected the original bill language would be an initial increase in the health care expense cost trend by approximately one percent (0.01) but in the long term, the volatility will smooth out and correct itself. This increase in the trend level will be reliant on the proposed fee schedule changes; how close the change is to the 12 month effective date; and the exclusions proposed by amendment 011807. Due to this, the estimated impact, based on the current contracts would be three-tenths of one percent (0.003) of claims in the first full plan year (calendar year 2018) and fifteen-hundredths of one percent (0.0015) of claims in the second full year (calendar year 2019). Beyond this timeframe, the actuary predicts the healthcare carriers and providers to incorporate the new process into the rate negotiations when it will smooth out and correct itself.
- Based on information provided by the Division, the estimated total cost in calendar year 2016 is $922,923,700 for both the state and local education plans. A three-tenths of one percent (0.003) increase in calendar year 2018 would result in an increase of $2,768,771. The state's portion of this is estimated to be $1,751,352 with federal funds of $72,430.39. The possible FY17-18 impact would be $875,676 ($1,751,352 x 50%) in state funds and $36,215 ($72,430.39 x 50%) in federal funds.

IMPACT TO COMMERCE WITH PROPOSED AMENDMENT:

Increase Business Revenue – $54,945,000

Increase Business Expenditures – $54,945,000

Assumptions for the bill as amended:

- Health insurance carriers will incur additional one-time and recurring expenditures to make the necessary changes to the current functionality and user interfaces. There will also be additional administrative costs to meet the requirements of the bill as amended.
- Based on information provided by the carriers who are currently contracted with the state through the Division of Health Care Finance and Administration or the Division of

Benefits Administration, these costs vary per carrier, but range from $10,000,000 to $16,000,000 per carrier.

- A report completed by an insurance regulatory consulting firm at the request of the Department of Commerce and Insurance estimates costs per carrier could easily exceed $8,600,000. For purposes of the fiscal analysis, it is reasonably estimated that any costs will average $9,000,000 per insurance carrier.
- The Department of Commerce and Insurance believes these costs will be incurred by six health insurance carriers in the state resulting in one-time costs of $54,000,000 ($9,000,000 x 6 carriers).
- Health insurance carriers will be charged a tax on these expenditures resulting in an increase in additional one-time costs of $945,000 ($9,000,000 x 6 carriers x 0.0175).
- The total increase in health insurance carrier costs will be $54,945,000.
- It is assumed the insurance companies will pass these additional expenditures on to their customers through changes in fees, premiums, rates and other revenue streams; therefore, it is estimated there will be a recurring increase in business revenue exceeding $54,945,000 statewide.

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.

Krista M. Lee

Krista M. Lee, Executive Director

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